

**IN THE UNITED STATES PATENT AND TRADEMARK OFFICE**

First Named Inventor:	Daniel L. Dunn	Docket:	P186714.US.01
Application No.:	10/688,858	Confirmation No.	9455
Filing Date:	October 17, 2003	Examiner:	Le, Linh Giang
Title:	SYSTEM AND METHOD FOR ASSESSING HEALTHCARE RISKS	Group Art Unit:	3686

**IN THE UNITED STATES PATENT AND TRADEMARK OFFICE  
BEFORE THE BOARD OF PATENT APPEALS AND INTERFERENCES**

**APPELLANTS' REPLY BRIEF**

Dear Sir:

This Reply Brief is filed in response to the Examiner's Answer mailed on October 7, 2011. A Claim Appendix has been included herewith that provides a listing of the pending claims.

The following comments are made in response to the arguments in the Examiner's Answer. Applicants also maintain the arguments presented in their Appeal Brief submitted on July 22, 2011.

## **I. Status of Amendments**

Appellants acknowledge that an amendment to the claims was filed on January 16, 2009. However, no amendment has been made subsequent to the most recent Final Office Action dated February 23, 2011. The attached claims are the same as the claims that were pending prior to the Final Office Action of February 23, 2011 and no amendment to these claims has been proposed since the mailing of that Action. As such, the attached claims are the same as those filed with the Appeal Brief and are the claims that are the subject of this appeal.

## **II. Robertson and Bienvenu do not disclose, teach or suggest “assigning the prescription data for each prescription to at least one risk group based on at least one medical condition typically treated by the prescription.”**

In the Answer, as to claim 1, the Examiner asserts that “assigning the data to at least one risk group” is disclosed by Robertson at Page 4, Paragraph 64. *Answer at Page 8.* Robertson states “the prospective insured is classified into a risk group.” *Robertson, Paragraph 64, lines 1 and 2.* “Data” is not the same as “prospective insured.”

Moreover, claim 1 is directed toward “a computer-implemented method for assessing risk of insuring a healthcare patient.” The healthcare patient mentioned in the preamble of the claim is more akin to a “prospective insured” than the claimed “data” and even with the mention of a healthcare patient in the preamble of the claim, the assigning phrase of the claim does not state “assigning the healthcare patient to at least one risk group.” Rather, the claim particularly calls for “assigning the prescription data for each prescription to at least one risk group.” Data is not the same as prospective insured.

At Page 9 of the Answer, the examiner concludes that Robertson teaches the general risk classification technique and Bienvenu teaches the particular type of data. What Robertson

teaches is classifying a prospective insured into a risk group. Combining this with a type of data from Bienvenu does not remedy the deficiency that neither reference teaches or suggests assigning data, of any kind, to a risk group.

Still further, it is not the prescription data generally that is assigned, but rather “prescription data for each prescription” that is assigned. By addressing prescription data and doing so for each prescription, the claimed invention provides an advantage by allowing for “each prescription” of the prescription data to be grouped with prescriptions having similar clinical and risk characteristics and the groups may then be attributed with more or less weight when compared to other groups.

### **III. The Combination of the Cited References is Improper for Failing to provide an Articulated Reason with Rational Underpinning for Combining the Elements of Robertson and Bienvenu**

In the Answer, the examiner stands by the following reason to combine: “[1]having an effective system and method for assessing prescription drug history information stored in the databases, [2] processing the information and [3] incorporating the information in the insurance process.”

This does not indicate why one of skill in the art would have thought to incorporate the teachings of Bienvenu into the teachings of Robertson. It simply provides no reason to combine. As to [1], simply making it more “effective” cannot be sufficient. This is simply nothing more than saying that there was a desire to make it better with no indication as to why combining them would actually make it better. As to [2], this is merely an additional step that might be performed once the references were combined. As to [3], incorporating the information in the

insurance process may reflect the result of combining the teachings of Bienvenu with Robertson, but does not provide a reason to combine them in the first place.

The examiner goes on to state, at page 11 of the answer, that one of skill in the art would be motivated to combine the teaching of Bienvenu and Robertson in order to have a complete system to insure risk of a healthcare patient. Robertson, however, relates to auto insurance, not health care. Why would one of skill in the art look to the teachings of Bienvenu to supplement the auto insurance teachings of Robertson? This new reasoning provided by the examiner reflects further hindsight reasoning because the proffered reason for the combination is to get to the end that is claimed. The use of hindsight reasoning is discussed in more detail in Appellant's Appeal Brief.

No apparent reason to combine the references has been provided by the examiner and, as such, a prima facie case of obviousness has not been established.

**CONCLUSION**

Applicant respectfully requests the reversal of the pending rejections of claims 1-10 for the reasons set forth above.

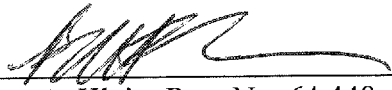
Should any additional fees be necessary, the Commissioner is hereby authorized to charge any fee deficiency associated with this paper or request to Deposit Account No. 04-1420.

Respectfully submitted,

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Date: 12/7/2011

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## CLAIMS APPENDIX

What is claimed is:

1. A computer-implemented method for assessing risk of insuring a healthcare patient, the method comprising one or more computers performing the following:
  - receiving demographic data on a patient and prescription data for each prescription filled by the patient;
  - assigning the prescription data for each prescription to at least one risk group based upon at least one medical condition typically treated by the prescription;
  - storing risk data for the patient, wherein the risk data includes the risk groups for all prescription data of the patient; and
  - calculating a risk score for the patient based upon the risk data and the demographic data of the patient.
2. The method of claim 1, wherein the step of assigning the prescription data to at least one risk group comprises using national drug codes to classify each prescription.
3. The method of claim 2, wherein the step of assigning the prescription data to at least one risk group further comprises categorizing each national drug code classification into one of a number of pharmacy risk groups.
4. The method of claim 1, further comprising defining additional member risk markers based on patient age and other characteristics known to indicate that the patient belongs to a high risk category and using the additional member risk markers to calculate the patient's risk score.
5. The method of claim 1, further comprising providing a clinical and demographic risk profile for the patient based on the patient's age, gender and a mix of clinical and demographic risk profiles and using the patient's clinical and demographic risk profile to calculate the patient's risk score.

6. The method of claim 5, further comprising providing multiple patient risk markers for patients with pharmacy services that indicate multiple medical conditions.
7. The method of claim 1, wherein each risk group is assigned a numerical risk value based upon the patient's demographic data, and the patient's risk score is the sum of the numerical risk values of the risk groups in the patient's risk data.
8. The method of claim 7, wherein the risk score is computed using pre-determined weights and a patient's patient risk marker profile.
9. The method of claim 3, wherein the pharmacy risk groups comprise patient risk markers.
10. An information processing system comprising:
  - a computer processor for:
    - receiving demographic data on a patient and prescription data for each prescription prescribed for the patient;
    - assigning the prescription data for each prescription to at least one risk group based upon at least one medical condition typically treated by the prescription;
    - storing risk data for the patient in an associated database, wherein the risk data includes the risk groups for all prescription data of the patient; and
    - calculating a risk score for the patient based upon the risk data and the demographic data of the patient.